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ABSTRACT

This newsletter supplement is devoted to the theme of domestic violence affecting migrant women. It contains four articles describing programs providing violence prevention education to migrant women and children. "Family Violence and Migrant Women: Implications for Practice" (Rachel Rodriguez) discusses the social isolation of migrant women; types of abuse, including preventing access to health care; abuse as an issue of power and control (not culturally acceptable behavior); the role of alcohol and substance abuse; and research needs. "Screening for Spouse Abuse in Primary Care Settings" (Janet Quillian) describes the incidence of physical abuse of women and teenage girls by husbands or boyfriends; abuse during pregnancy and related pregnancy and infant outcomes; and identification, documentation, and possible interventions by health professionals. "Battered and Pregnant" (Judith McFarlane) presents research that examined the prevalence of physical or sexual abuse among pregnant women; differences in incidence and severity among Anglos, Hispanics, and African-American women; and women's willingness to report abuse verbally to a health care provider as opposed to recording it on a medical intake form. "Battering of Migrant Women: A Migrant Outreach Program's Response" (Angela J. Cole) describes efforts of a Cumberland County (New Jersey) migrant health center to address the high incidence of domestic violence in migrant-worker camps, including outreach services, needs assessment, distribution of bilingual lists of "area resources" related to domestic violence, staff in-service education, and a school-based program aimed at influencing children's attitudes about violence toward women. Also included is a domestic violence assessment form in English and Spanish. (SV)

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Family Violence and Migrant Women: Implications for Practice

By Rachel Rodriguez, RN, PhD, Texas Woman's University, Houston, Texas

Women's Roles and the Migrant Lifestyle

It is well known among those working with migrant farmworkers that little has changed over the last 30 years. Living conditions are harsh and dangerous for the entire family. For farmworker women, the majority of whom work in the fields alongside their husbands, life is particularly difficult.¹ After working 10 to 12 hours in the field, a woman's work day continues with housework and child care. Women frequently complain of being tired and having no time to rest. These long work days preclude much interaction with other women in the camps. Describing life in the camps, one woman stated, "You rarely see women talking to each other. There is no time to worry about the other person."²

Another characteristic of life in the camps frequently described by farmworker women is the spreading of gossip. Women have said they don't talk to other women because there is too much gossip. When asked who they talk to about health problems or questions, women often say they talk to no one, and that it is difficult to find someone they can trust.²

The lack of time for interaction with other women coupled with the spreading of gossip in the camps can lead to a form of self-imposed social isolation for migrant women. This isolation combined with transportation and communication barriers (i.e., lack of telephones) can be deadly for a battered migrant woman. She may have no way out of a dangerous situation and no one to turn to for help.

The Problem of Family Violence

The prevalence of family violence among farmworker women is difficult to assess. Comprehensive studies that document the scope of the problem do not yet exist. However, both clinicians and farmworker women have anecdotal information that highlights domestic violence as a major concern for migrant health.

It is important to keep in mind that, while physical violence is the most obvious, abuse can take many forms. Clinicians must also be aware of the signs of economic, emotional, and sexual abuse. These are often more difficult to identify, particularly with Hispanic women who may be reluctant to discuss intimate details of their lives.

Another form of abuse that is often overlooked by health care providers is forced avoidance. In a recent ethnographic study, farmworker women were asked if anyone had kept them from accessing health care.² In every affirmative case, women identified male partners as the people who would not allow them to go for health care. This form of abuse may be even more common than the physical abuse described by many farmworker women.

Implications for Migrant Health

Violence and abuse, in whatever form, are issues of power and control. Health care workers must be cognizant of this fact in light of other, "socially acceptable," reasons for violence against women, such as poverty, discrimination, and substance abuse. Those working in migrant health must remember that domestic violence crosses all socioeconomic levels and is common in every

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culture. Although farmworkers suffer economic and racial discrimination from virtually every segment of society, these issues must be viewed as separate from the issue of domestic violence, lest the violence be "excused" as a result of societal mistreatment of the population. While all farmworkers are mistreated in some form by society, not all farmworker men beat their wives.

Alcohol and other substance abuse must also be viewed separately from domestic violence. There is no research to date that supports a cause-and-effect relationship between alcohol and domestic violence. The myth that those under the influence are less inhibited, less aware and, therefore, less accountable for their behavior contributes to ineffective strategies for protecting battered women. Treating the chemical dependency will not stop the violence in most cases. Anecdotal reports from battered women indicate that when batterers get sober the violence escalates. The few women who report a decrease in violent episodes report an increase in other forms of abuse such as threats, manipulation, and isolation.³

It is important to view power and control within the context of culture. The provider must be keenly aware of the difference between culturally-acceptable relationships between partners and coercive behaviors. For instance, while Hispanic farmworker women generally do not go out alone (without husbands and/or family members), male control over their use of health care resources is not an issue of cultural values — it is an issue of power and control.

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Screening for Spouse Abuse in Primary Care Settings

By Janet Quillian, DrPH, FNP, CPNP, Director of Family Nurse Practitioner Program, Department of Nursing, University of Nevada, Las Vegas, Nevada

In the past three decades domestic violence in the United States has become increasingly more evident. Domestic violence is found among all educational, economic, social and ethnic groups. Annual health care costs incurred from this problem are reported to be \$44 million.

Domestic violence is defined as an act or series of acts against an individual within a familial relationship that leads to emotional, physical, or sexual injury. Domestic violence encompasses child abuse, elder abuse, incest, spouse abuse and sibling abuse. The most prevalent form of domestic violence, however, is spouse or partner abuse. Although data indicates that there is no typical victim, victimized women are generally under 35 years of age.

Spouse abuse is a leading cause of injury for women between the ages of 15 and 44 years. One third of murdered women in the United States are killed by husbands, ex-husbands, or boy-friends. Yet for some women, emotional abuse is the most devastating because of its insidious nature and long-lasting psychological effects.

Physical abuse is also seen among dating teenagers. Some 12 to 22 percent of female teenagers are involved in abusive relationships, as are pregnant women. In fact, violence against women often begins in pregnancy. It is estimated that one in every 50 pregnant women will be physically abused, and that these women will receive an average of 4.5 beatings during each pregnancy. Pregnant women are often hit and kicked in the abdomen. These injuries can affect their infants.

Health outcome data on pregnant women who have suffered violence indicate they have more pre-term deliveries, more miscarriages, a greater

frequency of low birth weight infants, and an increase in incidence of fetal injuries and losses. The majority of these women are at peak child bearing ages.

The abused women rarely reports violence against her. Therefore the true incidence of spouse abuse is not known. It is estimated, though, that every 7.4 seconds a woman is abused. National surveys indicate that each year in the United States approximately 2 million women are physically abused. If spouse abuse is defined less stringently, i.e., slapping and pushing, the estimates increase to approximately six million. Spouse abuse is a major health problem.

The Role of Health Professionals in Spouse Abuse

The Year 2000 Health Objectives have cited violence and abusive behavior as a major health issue. Consequently, efforts have been undertaken to make health care providers responsive to domestic violence among women. National leaders and organizations have called for the health care system to respond to domestic violence.

Health professionals should be aware of three stages of spouse abuse. The first stage entails a women presenting with injuries on the head, face and body.¹ At stage two, visits are made to primary care settings/ambulatory sites. Complaints may be vague or may consist of nervousness, headaches, potential gynecologic problems, or tearful references to unspecified marital problems. Abused women also miss scheduled appointments. Unfortunately, women may receive symptomatic treatment that fails to address abuse as the primary issue.

In stage three, abused women manifest signs of alcoholism, anxiety, depression, drug addiction, suicide attempts, and inability to cope. Because spontaneous disclosure of abuse is rare, health professionals must screen for abuse by asking about it. This is the single most important service that health professionals can provide to women.

Screening for Spouse Abuse

All women should be routinely screened for physical abuse. Eliciting this information requires skill and sensitivity. Many abused women have stated they would have admitted to abuse if questioned in a supportive manner. Questions about abuse alert the health professional to potential or existing problems. Additionally, health professionals should understand that child and spouse abuse often co-exist within the same family.

Assessment of abuse implies the responsibility of intervention. If a woman responds affirmatively to any or all of the screening questions, then education, counseling, and referral are warranted. All women should be given telephone numbers of local community resources, whether they admit to abuse or not.

Primary care settings should have telephone numbers and pamphlets with information on local domestic violence resources in all patient waiting rooms.

Documentation Once spouse abuse is confirmed, health professionals should document the type, occurrence, location, and any factors pertaining to abuse. If physical injuries are displayed, then documentation of the following information is useful in making appropriate referrals: circumstances of the injury or event, victim's relationship to the assailant, concurrent use of alcohol or drugs by all parties, history of risk factors, history of intentional injuries or violent behaviors, predisposing biologic risk factors, and intent to seek revenge.

Screening is an intervention strategy that can reduce morbidity and mortality from spouse abuse through early recognition. Assessment for abuse should be standard for all women patients. Protocols for identification and intervention are warranted in all health care settings. ♦

REPRINTS

The Clinical Supplement to *Migrant Health Newslines* is developed by the Migrant Clinicians Network. For full copies of articles including references, to submit articles for consideration, or for more information about MCN, contact the Network at 1515 Capital of Texas Hwy. South, Ste. 220, Austin, TX 78746, (512) 328-7682.

Battered and Pregnant

By Dr. Judith McFarlane, Principal Investigator, Abuse During Pregnancy Study;
reprinted with permission from the American Medical Journal, June 17, 1992

My husband beat me during each pregnancy. He threw away the vitamins and would not let me go back to the clinic. He said I didn't need the medicine for the kidney infections. I was too scared to go to the emergency room. I knew the doctor or nurse would look at me and ask, or wonder, Why does she stay? Why does she not leave? All those kicks, all those beatings, all those falls, there was no one for me. I would sit alone at night and imagine receiving a hug.

35-year-old mother of six

The horror of abuse during pregnancy is a reality for one in six pregnant women. An ethnically stratified cohort of 1,200 African-American, Anglo, and Hispanic pregnant women were followed throughout pregnancy in Houston, Texas and Baltimore, Maryland to determine the frequency, severity, and location of physical abuse during pregnancy and associated characteristics of the abuser and entry into prenatal care.

Using a three-question Abuse Assessment Screen, data on the first 691 women to deliver detected a 17 percent prevalence of physical or sexual abuse during pregnancy. Abuse was recurrent, with 60 percent of the abused women reporting two or more episodes of violence. Anglo women experienced the most episodes of abuse. Additionally, when compared with African-American and Hispanic women, Anglo women experienced more severe episodes of abuse. When potential danger for homicide was evaluated, Anglo women were in the most danger.

Consistent with reported marital status, the perpetrator of abuse was almost always someone the woman knew intimately. Multiple perpetrators tended to be reported by teenagers, who cited both a boyfriend and parent as abusive. Entire body abuse was more likely to be experienced by Hispanics and Anglos, with a combination of assaults (e.g., head and torso or head and extremities) reported more frequently by African-Americans.

Although physical abuse has never been directly implicated or measured as a barrier to prenatal care, in this study abused women were twice as likely to begin prenatal care during the third trimester. Physical abuse, with the associated perpetrator behaviors of power and control endemic to the cycle of violence, may function as a barrier to accessing parental care.

Clinical implications are straightforward. Three assessment questions asked

in a private setting indicated that one in six pregnant women was abused. The Abuse Assessment Screen, when administered by the primary provider, is valid and reliable. In a related study by this investigator, self-report for abuse was measured against primary provider assessment. Approximately 8 percent of women self-reported abuse on a standard medical history intake form, but when asked the same abuse assessment question by a health care provider, 29 percent reported abuse. Women must be asked about abuse in a private setting, away from their male partner, by a trained health care provider.

Once identified, the abused woman

Family Violence and Migrant Women

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Outreach provides some of the best opportunities for reaching battered migrant women. The outreach worker may be the only person in whom the woman can confide. While doing follow-up for missed appointments or other health assessments, the worker should also assess for signs of abuse. Outreach workers should be trained in the area of domestic violence and have access to resources and information that can be passed along to the migrant woman. Health information workshops held in camps should include a session on domestic violence.

Research must be conducted to document the prevalence of domestic violence among migrant farmworker women. Collaborative projects would be ideal for tracking battered women as they move throughout the migrant streams. Domestic violence also has serious implications for other health research conducted with farmworker populations, e.g., medical utilization patterns or maternal-child health outcomes.

Qualitative studies using focus groups

needs education, advocacy, and referral information. Strategies for intervening during pregnancy begin with a thorough in-service of health care providers on the extent of the problem, how to assess and counsel for abuse, and advocacy methods for enabling the woman to access needed community services. Typically, pregnancy is the only time that healthy women come into frequent contact with health care providers. Additionally, women of child bearing age are young (one-third of this sample of pregnant women were teenagers) and, for many women, a lifetime of abuse may have just begun. Pregnancy is a window of opportunity to assess all women for abuse, document the extent of the abuse, and offer information on community services. Assessment may interrupt the cycle of abuse and prevent further violence, thereby protecting both mother and child.

For further information, contact Dr. Judith McFarlane, College of Nursing, Texas Woman's University, 1130 M.D. Anderson Blvd., Houston, TX 77030, (713) 794-2138. ♦

and/or individual interviews with farmworker women would enable women to describe their experiences and provide realistic options for addressing the domestic violence. This data could be the foundation for developing practical, workable strategies for health care providers working with battered migrant women.

Migrant farmworker women face many of the same barriers to health as other disadvantaged populations. However, their transient lifestyle coupled with their geographic and social isolation makes domestic violence an especially dangerous problem. Those working in migrant health must be aware of the issues regarding domestic violence and their implications for farmworker women.

For more information contact Rachel Rodriguez, PhD, (after August 1, 1993) at the University of Colorado Health Science Center, School of Nursing, 4200 E. 9th Ave., Denver, CO 80262. For a national directory of domestic violence programs, contact the National Coalition Against Domestic Violence, 303/839-1852. ♦

Battering of Migrant Women: A Migrant Outreach Program's Response

By Angela J. Cole, MPH, RN, Migrant Program Coordinator, Community Health Care, Inc., Bridgeton, New Jersey

Community Health Care, Inc. (CHCI) is a federally funded community/migrant health center with sites in Bridgeton and Vineland, New Jersey. Its service region encompasses Cumberland County, an agricultural area of over 200 known migrant camps. While the majority of camps house single men, a significant number of women live in multi-family housing within the city limits of Bridgeton and Vineland.

The barriers to primary health care and social services faced by migrant farmworkers of this area are the same ones faced by farmworkers everywhere: language differences, lack of transportation, and unavailability of services. Our Migrant Outreach Program attempts to eliminate those barriers by providing translators, transportation, outreach, and evening clinic hours specifically for farmworkers. We also conduct health education in the camps.

Last fall, staff members identified a high incidence of domestic violence in the camps and expressed concern that the needs of battered migrant women were not being addressed. No resources had been identified for these women, and health center staff were not knowledgeable about identification and management of battered migrant women.

Although providing services to battered women presents many challenges, battered migrant women face unique problems. Differences in culture, immigration status, and lan-

guage, as well as a lack of knowledge of available services, further compound the situation of many of the migrant women our health center serves.

CHCI identified several basic programmatic needs: 1) to assess the scope of the problem among migrant women in our area; 2) to identify existing community resources for battered women, especially Spanish-speaking women; 3) staff education; 4) early preventive education within the community; and 5) support groups where migrant women could safely and confidentially discuss issues and options available to combat violent situations.

In order to identify the social service and health care needs of migrants who stay in Cumberland County during the winter, we conducted a needs assessment using a survey questionnaire designed for personal interviews in Spanish or English.

The questions assessed health care and social service needs, but the section pertaining to domestic violence was only presented to women when no men were present. To introduce domestic violence questions, interviewers first read a brief paragraph about fighting in the home and resultant injury to women and children. Respondents were then asked, "If someone came to you who had been mistreated by fighting in the family, would you know how to help them?" Participants who answered "no" were offered written material from the

Cumberland County Women's Center.

Even when males were present during the interview, respondents were given a bilingual "Area Resources" sheet containing the telephone numbers of local social service agencies, fire and police departments, and even a Spanish-speaking taxi service. This "back door" approach ensured that every woman interviewed received the name and number of the appropriate agency to call in case of family violence.

To address the need for staff education, a domestic violence in-service was held. The program addressed not only the cycle of domestic violence and the associated issues in the general population but also the specific issues present in migrant groups. A multi-disciplinary range of staff members participated in the education program.

CHCI supports a school-based program through Cumberland County schools. Roots of domestic violence have been noted in attitudes expressed by elementary school children. Those attitudes indicate that violence against women in general, as well as violence against high school females (i.e., sexual harassment, date rape), are acceptable. Because education is believed to be a primary method of domestic violence prevention, efforts to obtain appropriate resources for early intervention programs have begun.

Although there is a support group for battered women in the community, a group specifically designed for migrant women is still needed. The Women's Center and CHCI are working together to establish such a group. Forming linkages with existing domestic violence programs in the county, as well as collaborative relationships with community-based social service agencies, has proved to be a successful method for migrant health programs to address domestic violence. As CHCI continues to expand its services, comments from other programs are welcome. Contact Angela J. Cole, MPH, RN, Community Health Care, Inc., 105 Manheim Avenue, Bridgeton, NJ 08302, (609) 451-4700. ♦

MCN Adopts Domestic Violence Assessment Form

This issue of the Clinical Supplement contains a camera-ready Domestic Violence Assessment, with English questions on one side and Spanish on the other. The form was developed by Dr. Judith McFarlane and adapted for use with migrant farmworker women by the Migrant Clinicians Network.

MCN encourages the use of this screening form by all migrant health care providers. The form may be copied as necessary.

MIGRANT CLINICIANS NETWORK

Domestic Violence Assessment Form

NOTE TO PROVIDER: If the client chooses to talk about child abuse which occurs in her home, the law in your state may require you to report suspicions of child abuse to state authorities. If this occurs, you need to discuss the reporting process with the client. Other than suspected child abuse, all information recorded on this form should remain confidential.

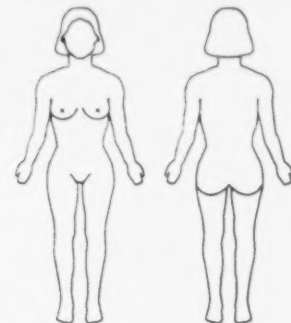
Client Name: _____ Chart No.: _____ Date: _____

Provider: _____ Clinic: _____

1. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO
- If YES, by whom? (circle all that apply) HUSBAND EX-HUSBAND BOYFRIEND RELATIVE STRANGER OTHER
- Total number of times: _____

Please mark the area of injury on the body map. Score each incident according to the following scale:

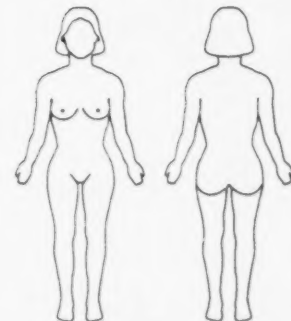
- 1 = Threats of abuse including use of a weapon
- 2 = Slapping, pushing, no injuries and/or lasting pain
- 3 = Punching, kicking, bruises, cuts and/or continuing pain
- 4 = Beating up, severe contusions, burns, broken bones
- 5 = Head injury, internal injury, permanent injury
- 6 = Use of weapon, wound from weapon



2. If pregnant, since the pregnancy began have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO
- Total number of times: _____

Please mark the area of injury on the body map. Score each incident according to the following scale:

- 1 = Threats of abuse including use of a weapon
- 2 = Slapping, pushing, no injuries and/or lasting pain
- 3 = Punching, kicking, bruises, cuts and/or continuing pain
- 4 = Beating up, severe contusions, burns, broken bones
- 5 = Head injury, internal injury, permanent injury
- 6 = Use of weapon, wound from weapon



3. Within the last year, has anyone forced you to have sexual activities? YES NO
- If YES, who? (circle all that apply) HUSBAND EX-HUSBAND BOYFRIEND RELATIVE STRANGER OTHER
- Total number of times: _____

4. Are you afraid of your partner or anyone you listed above? YES NO

This form was developed by Dr. Judith McFarlane, College of Nursing, Texas Woman's University, Houston, Texas. The form was adapted by the Migrant Clinicians Network for use in a migrant health center setting and used with permission. This form may be duplicated as needed. For more information, contact MCN at 1515 Capital of Texas Hwy. South, Ste. 220, Austin, TX 78746, (512) 328-7682.

MIGRANT CLINICIANS NETWORK

Evaluación Sobre Abuso Físico

AVISO A PROVEEDORES DE SERVICIOS: Si su cliente escoge discutir abusos físicos cometidos en contra de menores en el hogar, tenga en cuenta la ley de su estado: ésta ley posiblemente demanda reportar a los autoridades locales estas sospechas. Si esto ocurre, usted debe discutir el reporte de estas actividades con su cliente. El resto de la información incluida en esta forma debé mantenerse confidencialmente.

Nombre de Cliente: _____ Archivo No.: _____ Fecha: _____

Proveedor: _____ Clínica: _____

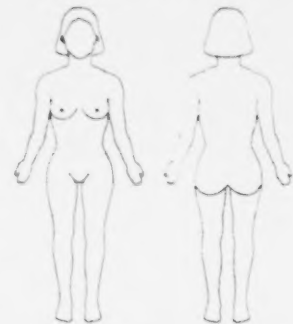
1. ¿Durante el último año, ha sido usted lastimada físicamente (golpes, patadas, bofetadas) por otra persona? Sí ☐ NO ☐

Si afirmativa, ¿por quien? ESPOSO EX-ESPOSO NOVIO PARIENTE DESCONOCIDO OTRO

Numero total de ocasiones de abuso: _____

Marque en el mapa corporal el area golpeada. Apunte cada incidente según la siguiente escala:

- 1 = Amenazas de abuso incluyendo el uso de alguna arma
- 2 = Bofetadas, empujones sin lesiones ni dolor prolongado
- 3 = Punetazos, patadas, cortadas o lesiones con dolor prolongado
- 4 = Golpes, contusiones severas, quemaduras, huesos fracturados
- 5 = Lesiones en la cabeza, lesiones internas, lesiones permanentes
- 6 = Uso de arma, herida por uso de arma

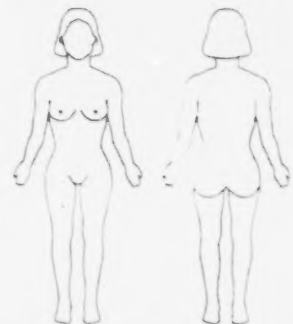


2. ¿Durante el embarazo fue ud. golpeada o lastimada físicamente? Sí ☐ NO ☐

Numero total de ocasiones de abuso: _____

Marque en el mapa corporal el area golpeada. Apunte cada incidente según la siguiente escala:

- 1 = Amenazas de abuso incluyendo el uso de alguna arma
- 2 = Bofetadas, empujones sin lesiones ni dolor prolongado
- 3 = Punetazos, patadas, cortadas o lesiones con dolor prolongado
- 4 = Golpes, contusiones severas, quemaduras, huesos fracturados
- 5 = Lesiones en la cabeza, lesiones internas, lesiones permanentes
- 6 = Uso de arma, herida cometida por el arma usada



3. ¿Ha sido ud. forzada a tener relaciones sexuales durante el último año? Sí ☐ NO ☐

Si afirmativa, ¿por quien? ESPOSO EX-ESPOSO NOVI PARIENTE DESCONOCIDO OTRO

Numero total de ocasiones de abuso: _____

4. ¿Tiene usted miedo de su pareja o de alguna de las personas mencionadas anteriormente? Sí ☐ NO ☐

Este cuestionario fué elaborado por la Dra. Judith McFarlane, College of Nursing, Texas Woman's University, Houston, Texas. El cuestionario fué adaptado por el Migrant Clinicians Network para uso en un centro de salud migrante. Uso y reproducción de este cuestionario es permitido. Para más información, comuníquese con MCN en 1515 Capital of Texas Hwy. South, Ste. 220, Austin, TX 78746, (512) 328-7682.